BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF WASHINGTON

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| In the Matter of the Application Regarding the Conversion and Acquisition of Control of Premera Blue Cross and its Affiliates. | NO. G 02-45<br><br>INTERVENERS' POST-HEARING BRIEF |

Pursuant to the Commissioner's Twenty Third Order, Interveners Washington Hospital Association, Association of Washington Public Hospital Districts, Washington State Medical Association, and Premera Watch Coalition submit this post-hearing brief. For the following reasons, Interveners respectfully request the Commissioner to reject Premera's proposed for-profit conversion unconditionally.

## I. STANDARD OF REVIEW

Interveners' Responsive Pre-Hearing Brief addresses the standards under the Holding Company Acts and will not be repeated here. Some of the arguments put forward by Premera during the administrative proceeding require additional discussion of the legal framework, however.

### A. The Insurance Commissioner has broad discretion.

Premera argues that the evidence submitted by the OIC Staff experts and the experts offered by the Interveners is not "predictive" of Premera's post-conversion activities. Milo Closing Statement, Tr. 2527:4-2528:7. The standards under the Holding Company Acts,



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however, do not mandate that the Insurance Commissioner be able to predict the future results of the transaction with 100 percent certainty. Rather, the Acts require the Insurance Commissioner to analyze the possible effects of the proposed transaction and to determine, within his broad discretion under the Insurance Code, whether those possible outcomes may adversely impact policyholders and the public. RCW 48.31B.015; 48.31C.030. For example, the Acts allow the Commissioner to reject a conversion if the future financial condition of an acquiring party *might* jeopardize the financial stability of the insurer or prejudice the interest of policyholders. RCW 48.31B.015 (4)(a)(iii); 48.31C (5)(a)(ii)(C)(I). The statutes also require the Commissioner to determine whether the transaction is *likely* to be hazardous or prejudicial to the insurance-buying public. RCW 48.31B.015 (4)(a)(vi); 48.31C (5)(a)(ii)(C)(IV).

Evidence submitted by the parties need not be absolutely predictive of a particular outcome in order for the Commissioner to use the evidence to support his decision in this matter. Reasonable calculations, models, and analyses by experts in this proceeding may be relied upon by the Commissioner, even if the experts could not state with complete certainty that Premera will engage in the specific deleterious post-conversion behavior. Thus, in order to disapprove the proposed transaction, the Commissioner need only find that that the conversion is likely to be hazardous or prejudicial to the insurance-buying public, might prejudice the interests of policyholders, or be unfair and unreasonable to subscribers and the public interest.

The Commissioner's factual findings in this regard must be based upon "a sufficient quantity of evidence to persuade a fair-minded person of the truth or correctness of the order." *City of Redmond v. Central Puget Sound Growth Mgmt. Hearings Bd*, 136 Wn.2d 38, 46 (1998) (citing *Callecod v. Washington State Patrol*, 84 Wn. App. 663, 673, *review denied*, 132 Wn.2d 1004 (1997)). Washington courts have upheld final agency decisions after administrative hearings where the decisions were based upon substantial evidence in the



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record that included reasonable calculations, models, and projections. *See US West Communs., Inc. v. Utilities & Transp. Comm'n*, 134 Wn.2d 48, 68 (1997) (In a case involving depreciation accounting in the telecommunications industry, the Supreme Court upheld the final agency decision, commenting, "[t]his case was essentially a battle of the experts on the effect competition will have on the telecommunications industry, how quickly new technology will need to be implemented, and those events' effect on the lives of currently used equipment"); *Providence Hosp. of Everett v. Department of Social & Health Services*, 112 Wn.2d 353, 358 (1989) (The Washington Supreme Court upheld the agency's denial of a hospital certificate of need based, in part, on the agency's analysis of the future or proposed facilities in the local community); *Purse Seine Vessel Owners Ass'n v. State*, 92 Wn. App. 381, 389 (1998) (The state agency's decision to keep non-treaty fisheries closed was a factual determination based upon biologists' projections about the 1997 fish season, and was upheld by the Court of Appeals).

In a similar situation, the Kansas Supreme Court upheld the Insurance Commissioner's decision to reject a Blue Cross takeover by a for-profit company (Anthem) under that state's Holding Company Act based upon expert testimony regarding projected premium increases that could result post-transaction. *Blue Cross & Blue Shield of Kan., Inc. v. Praeger*, 276 Kan. 232, 75 P.3d 226 (2003). In that case, which was decided under a legal framework similar to our Holding Company Acts, the experts hired by the Insurance Commissioner's staff, PricewaterhouseCoopers, conducted a market impact analysis of the "likely changes" that would occur in the health insurance market in Kansas if the transaction were approved. *Id.* at 239. The Kansas experts found that in order to achieve the targeted underwriting margins identified by Anthem, the company would likely increase premium rates above the trend, in the individual and small group markets. *Id.* at 240-241. The Commissioner found that the potential increase in premium rates could place a significant financial burden on the company's policyholders, the public and the insurance-buying public.



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*Id.* at 242. On appeal, the Kansas Supreme Court upheld the agency decision, finding that there was substantial evidence in the record to support the Commissioner's decision. *Id.* at 263. *See also* Brief of *Amicus Curiae* National Association of Insurance Commissioners (NAIC) in *Blue Cross & Blue Shield of Kan., Inc. v. Praeger* (NAIC argues that the Model Holding Company Act, upon which the Kansas and Washington HCAs are based, requires consideration of evidence about future plans of the insurer) (hereinafter "NAIC Brief"; copy attached hereto as **Attachment A**).

At any rate, the legal question of the burden in proof in this proceeding is beside the point because substantial evidence in the record amply demonstrates that Premera's proposed conversion is not in the public interest.

**B. <u>The Commissioner's consideration of "the public interest" includes the general public in Washington state.</u>**

In its pre-hearing brief, Premera argues that consideration of the "public interest" is limited to the impact of the proposed conversion on its current and future subscribers. Premera Pre-Hearing brief at 38. Premera is simply wrong: the scope of the "public interest" in Washington insurance matters is exceedingly broad. *See Insurance Co. of North America v. Kueckelhan*, 70 Wn.2d 822, 833 (1967) (One of the legislatively announced purposes of the examining bureau [OIC] is to protect the "citizens of this state."); *Kueckelhan v. Federal Old Line Ins. Co.*, 69 Wn.2d 392, 405-406 (1966) (The state, on behalf of the general public welfare, has a "vital interest" in the financial well-being of insurance companies); *Continental Ins. Co. v. Fishback*, 154 Wash 269, 276 (1924) ("It seems to have become settled by the decided weight of authority, and so recognized in this state, that the insurance business is affected with a public interest such as will subject those engaged in it to regulation substantially to the same extent as public service corporations are subjected to regulation"). Indeed, references are made throughout the Insurance Code to both the interest of policyholders and the interest of the public, indicating that those interests are separate and



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must be considered distinctly by the Commissioner. *See e.g.* RCW 48.05.140 (8); 48.05.450(2)(b); 48.07.210(2); 48.13.220(g); RCW 48.13.475 (1)(a)(ii). The repeated use by the legislature of both terms and the plain meaning of the term "public" clearly indicates that the public interest is a separate, distinct consideration from the interests of a company's insured. *See City of Bellevue v. Lorang*, 140 Wn.2d 19, 24 (2000) ("Unless contrary legislative intent is indicated, words are given their ordinary, dictionary meaning.").

Premera's position is also contrary to that of the National Association of Insurance Commissioners. In its Amicus Brief submitted in the Kansas case, the NAIC argued that the public interest should be defined broadly in the Holding Company Acts:

> Regulatory agencies in many areas have been given wide discretion when charged with protecting the "public interest." "[I]n determining what constitutes the 'public interest'... the Commissioner is entrusted with the function not merely of determining the existence or non-existence of certain facts, but also of exercising an expert judgment..." *Pittsburgh and Lake Erie Railroad Company v. United States*, 294 F. Supp. 86, 97 (W.D. Pa. 1968). "In general, where the Commission is required to consider the 'public interest,' it must look to 'the interest of the public, their needs and necessities and location and, in fact, all the surrounding facts and circumstances to the end that the people will be adequately served.'" *Browning Freight Lines, Inc. v. Wood*, 570 P.2d 120, 126 (Idaho 1978). "[P]ublic interest may be taken to encompass a wide range of considerations, from environmental, health and safety concerns to the financial concerns of employers, employees and ratepayers." *General Motors Corporation v. Indianapolis Power & Light Company*, 654 N.E.2d 752, 762 (Ind. App. 1995).

NAIC Brief at 6-7.

## C. Premera's Argument concerning the Burden of Proof is Erroneous.

Premera argues that the OIC Staff and the Interveners have not met the "burden of proof" required for the Insurance Commissioner to reject the proposed conversion. Tr. 2526, lines 18-19; Premera Pre-Hearing Brief at 32-33. However, neither the Holding Company Acts, the Insurance Commissioner's regulations, nor the Administrative Procedure Act (APA) identify a specific burden of proof that must be met by any party to this proceeding. Indeed,



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Premera's sole basis for alleging that the OIC Staff and Interveners bear some "burden of proof" is the language in the Holding Company Acts stating that the Insurance Commissioner must approve the transaction unless, after a public hearing, he finds that any of the six criteria for rejecting the proposal are met.[1] If Premera's argument were true, companies seeking approval under the Holding Company Acts would have an incentive to withhold needed information from the OIC Staff's review, in order to prevent the OIC Staff from meeting any purported "burden of proof."[2]

Premera's arguments also fail to recognize the unique nature of this administrative proceeding, in which all parties are encouraged to provide evidence upon which the Insurance Commissioner may base his decision. The parties have done so, and there is overwhelming evidence in the record upon which to base a decision to reject the proposed conversion.

Since there is no explicit burden of proof established in statute or case law for an administrative proceeding under the Holding Company Acts, the parties must look to the standards for judicial review to determine how the Commissioner must structure his decision in order to withstand later challenges. The APA establishes the standards for judicial review at RCW 34.05.570(3). A court will not re-weigh the credibility of the evidence presented at an administrative proceeding. *US West Communs., Inc.*, 134 Wn.2d at 62; *Providence Hospital of Everett*, 112 Wn. 2d at 360 ("It is not our function to reweigh the evidence in an effort to reach different conclusions than did the agency"). Rather, a court's investigation into the fact-finding of the proceeding will be to determine whether there is "sufficient evidence" in the record to support the final agency decision. RCW 34.05.570(3). Additionally, in a case involving complex matters within an agency's expertise – such as transactions under the

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[1] The language under the HCAs is insufficient to assign to any party a particular burden of proof. In other sections of the Insurance Code, the legislature specifically requires that OIC Staff or the Insurance Commissioner bear the burden of proof. *See* RCW 48.18.103(7) and 48.19.043 (7). In this section, no assignment is made.

[2] Premera's strategy of withholding specific information about its post-conversion plans may be at least partially explained by its legal position in this regard.



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Holding Company Acts – courts will grant significant deference to an agency's interpretation of an ambiguous statute. *Postema v. Pollution Control Hearings Bd.*, 142 Wn.2d 68, 77 (2000). This deference to the final agency determination is reflected in the Kansas Blue Cross case. *Blue Cross & Blue Shield of Kan., Inc.*, at 246-249.

## II. CONVERSION IS NOT IN THE PUBLIC INTEREST AND IS LIKELY TO BE HAZARDOUS OR PREJUDICIAL TO THE INSURANCE BUYING PUBLIC

### A. Conversion to For-Profit Status is Likely to Change Corporate Behavior in ways that will negatively impact the Public Interest.

The Washington health insurance market is and has been dominated by nonprofit insurers. The two largest health carriers – Premera and Regence – are both nonprofit Blue Plans. Combined, they have 59 percent of the market, insuring nearly 1,830,000 lives. An excellent description of the differences in orientation between for-profit and nonprofit health carriers comes from the Alliance for Advancing Nonprofit Healthcare,[3] an organization including as members many nonprofit Blues:

> The overriding purpose of nonprofit healthcare organizations is to "do good" for the benefit of their communities. Unlike investor-owned organizations, which are economically driven and legally obligated to do well financially for their owners, with profits primary, nonprofit healthcare organizations are obligated along with government at all levels to meet society's needs for medical education and research and to advocate for and meet the needs of the most vulnerable members of their communities. Profits of nonprofit healthcare organizations do not inure to the benefit of individuals and, while necessary over the long run, are secondary.

*See* http://www.nonprofithealthcare.org/learn.html (visited 5/25/04).

Blue Plans historically have been insurers of last resort – operating under a philosophy distinctly less bottom-line oriented than non-Blue companies. This history arises from their early affiliation with hospitals and physicians. Robert Cunningham III and Robert M. Cunningham Jr., The Blues: A History of the Blue Cross and Blue Shield System, 7-21, 30-

[3] The Alliance is an organization including many of the largest not-for-profit Blues, as well as Group Health Cooperative and Kaiser. *See* http://www.nonprofithealthcare.org/sponsors.html (visited 5/25/04).



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31, 37-55 (1997) (hereinafter "Cunningham"). Furthermore, and contrary to the testimony of Mr. Steel, Blue Plans have not historically considered themselves nor have they been treated as commercial enterprises. As the president of the BCBSA testified before Congress in 1986:

> There has always been an important difference between the Blue Cross and Blue Shield Plans and the commercial insurers, however. That difference is one of purpose and philosophy underscored by day-to-day operating practices. The Plans have a strong obligation to their communities, as well as to their subscribers, and discharge those community obligations in ways that do not add to the "bottom line." Commercial insurers do not share these community obligations and, quite understandably, operate to maximize the return to their shareholders.
>
> The philosophical differences between the plans and the commercial insurers lead to very real differences in behavior . . . .In short the Plans . . . maintain a pattern of behavior that is far more community-oriented that their competition.

U.S. Senate Comm. on Fin., 99th Cong. 2d Sess., 36-38 (Feb. 4, 1986) (Statement of Bernard R. Tresnowski, President, Blue Cross and Blue Shield Ass'n, Chicago, IL) cited in Joel Ferber, Jo Anna King, *A Cure for the Blues: Resolving Nonprofit Blue Cross Conversions*, 32 Journal of Health Law 75 (1999).

In *Group Life & Health Insurance Co. v. Royal Drug Co., Inc.*, 440 U.S. 205, 225, 99 S.Ct. 1067, 1080, 59 L.Ed.2d 261 (1979), the United States Supreme Court commented on whether a Blue Plan was engaged in the "business of insurance" for purpose of anti-trust regulation. Citing a decision by the Washington Supreme Court,[4] among others, the Court commented: "At the time of the enactment of the McCarran-Ferguson Act [in 1944], corporations organized for the purpose of providing their members with medical services

[4] *Royal Drug* cited our Supreme Court's early case *State ex rel Fishback v. Universal Service Agency*, 87 Wash. 413 (1915). *Universal Service Agency* was called into question by *McCarty v. King County Med. Serv. Corp.*, 26 Wn. App. 660 (1946). In the following year, the legislature reacted by passing the predecessor to RCW Ch. 48.44, Laws of 1947 c 268, which defines "Health Services Contractor" as "any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services." RCW 48.44.010(3). Prior to 1994, Health Services Contractors were exempt from premium taxation. RCW 48.14.0201.



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were not considered to be engaged in the insurance business at all, and thus were not subject to state insurance laws." The Court noted further that "Blue Cross and Blue Shield organizations themselves have historically taken the position that they are not insurance companies" and that most lower courts to consider the question "have also held that Blue Cross and Blue Shield plans are not insurance." *Id.* at 229, 233.

This history is consistent with the experience in Washington. The company currently known as Premera was formed by Washington charitable hospitals in 1945 for the purpose of advancing their charitable purposes by providing hospital care to those who could not otherwise afford it and to thereby promote the social welfare. Exhibit I-6. The Medical Service Corporation, which was acquired by PREMERA and later merged into Premera Blue Cross in the 1990's, was formed by physicians for the purpose of "secur[ing] to low wage earners and their families, health services ... of which many such individuals and their families have heretofore been deprived." Exhibit I-7. Indeed, MSC was incorporated under a former Washington statute expressly applicable to charitable corporations. Exhibit I-7; Steel Testimony, Tr. 1129:3-13.

**B. <u>Nonprofit Health Carriers have a Different Mission and Demonstrate Different Behavior than their For-Profit Counterparts.</u>**

Nonprofit Blue Plans have historically engaged in community-based rating and have allowed "cross-subsidization" of marginal lines of business, particularly safety net lines such as Medicaid and Medicare. Virtually every Blue Cross plan in the country was established with "community rating instead of rates based on an individual's health status to price their products." Cathy Tokarski, Mergers, Conversions: Blues' Survival Strategies, American Medical News, May 20, 1996, at 17. The plans offered "the same rates to all subscriber groups regardless of age, sex, occupation, or other characteristics that might affect the frequency with which members of the group would require hospitalization." Cunningham, at 31. As one early Blue Cross leader explained, the idea of underwriting subscribers' entire



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cost of hospitalization "violated basic insurance principles and was in direct contrast to the commercial insurance concept of paying a predetermined fixed indemnity to a policy holder against a loss." *Id. See Universal Service Agency*, 87 Wash. 413.

Blue Plans staging themselves for conversion, however, have generally adopted more "bottom-line" oriented practices several years prior to the actual conversion effort. Pierson Testimony, Tr. 2014; Exhibit P-28, Hall and Conover, The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest, vol. 81, no. 4 ("[A]nticipating conversion, BC plans usually begin to change their operations well before conversion in order to enhance the value of stock when it is first sold to the public.... Because this process may begin several years before the actual conversion, assessments may miss a conversion's true impact if they focus only on the one or two years immediately preceding conversion"). After conversion, for-profit Blue Plans generally adopt even more restrictive underwriting practices and reject cross-subsidization as a business philosophy. Larsen Testimony, Tr. 2215:20-2216:16; Pierson Testimony, Tr. 2014:16-19; Dauner Testimony, Tr. 2266:7-2267:18. As compared to nonprofits, for-profit plans also participate in safety-net type programs such as Medicaid at far lower rates than for-profits. *See Cost, Commitment & Locality, A Comparison of For-Profit and Not-for-Profit Health Plans,* Treo Solutions (2004), pp. 12-13, available at *http*://www.nonprofithealthcare.org/AllianceTreoReport-1-23-04.pdf (visited 5/25/04) (hereinafter "Treo Report," attached hereto as **Attachment B**).

Converted Blue Plans also exhibit other forms of corporate behavior likely to be hazardous or prejudicial to the insurance buying public. A survey of hospital associations in states with converted Blue Plans demonstrated that in several material aspects the corporate behavior of Blue Plans deteriorated after conversion and that in no instance did behavior improve: *i.e.*, in two of five jurisdictions surveyed, the plan's willingness to address the problems of the uninsured declined and flexibility in providing coverage declined; in three of five cases, the level of claim denials increased, the tenor of contract negotiations hardened,



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and the handling of disputed claims became more difficult; and four of five cases, the level of payment to providers declined. Exhibit I-16; Tr. 2010-12. In California, hospital surveys consistently show that, after the conversion of the state's Blue Plan, for-profit Wellpoint has behaved in a more aggressive manner than pre-conversion Blue Cross of California, and the handling of claims and payment for services has been worse. Dauner Testimony, Tr. 2263:10-1165:19.

Dissatisfaction with for-profit plans is not limited to providers. Consumer Reports surveyed 19,000 readers and showed that nonprofit HMO's rated much more highly in subscriber satisfaction than did not for profit plans. Health Care Survey Report, Consumer Reports Aug. 1999, p. 23. Four years later, the magazine surveyed 42,000 readers that overwhelmingly preferred nonprofit managed care plans to for-profits. See Benbow Testimony, Tr. 2334:15-24; HMO or PPO: Picking a Managed Care Plan, Consumer Reports Oct. 2003, at http://www.consumerreports.org/main/content/display_content.jsp?CONTENT%3C%3Ecnt_id =329183 (visited 5/28/04).

Consumer and provider dissatisfaction with for-profit Blue Plans no doubt stems in part from the fact that, in order to generate the profits shareholders demand, for-profit health plans have historically spent significantly less of each premium dollar on health care than nonprofits have. Katz Testimony, Tr. 2295:13-2296:2; Ex. I-54 at 14-18. Indeed, the unrebutted evidence in this proceeding supports this finding.

In a report prepared by the Kansas Insurance Department in December 2001 and cited by Calvin Pierson in his testimony regarding the proposed CareFirst conversion in Maryland, Carl Schramm found that investor-owned Blue Plans paid out 73.5 percent of revenue for healthcare, as compared for 80.1 percent by commercial carriers and 83.7 percent by nonprofit Blues.[5] Evidence from California indicates the same pattern with respect to the

[5] *Available at* http://www.ksinsurance.org/consumers/bcbs/public_testimony/intervenors/kms/statement_Schramm.pdf (visited 5/24/04).



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behavior of Wellpoint, which now pays out 79 percent of premiums for healthcare, as opposed to the approximately 90 percent that Blue Cross of California paid prior to conversion, and the 90-plus percent of premium currently paid for healthcare by nonprofit carriers in California. Dauner Testimony, Tr. 2266-67. Likewise, a recent study from New York showed a significant differential in medical expense ratios between markets dominated by for-profits (80.4 percent) and those dominated by nonprofits (87.7 percent). Treo Report at 12.

Despite these very significant reductions in healthcare payments, premium increases have not abated, and the amounts spent of administrative overhead such as salaries has gone up. *Id;* Dauner Testimony, Tr. 2267-68; Katz Testimony, Tr. 2295:13-2296:2. And while the converted healthcare plan maximizes its revenues and profits at the expense of medical payments to subscribes, its for-profit behavior has ripple effects in the community: The Treo Report shows that conversion of a major carrier in a previously nonprofit health insurance market forces the remaining nonprofits to behave more like for-profits in order to compete. Treo Report at 4-5.

**C. <u>The Evidence Shows that Premera is Likely to Follow a Similar Pattern.</u>**

Premera has exhibited a pattern of corporate behavior similar to that of other Blue Plans staging for conversion. For many years, and until recently, the company has participated in public insurance programs such as Medicaid, Medicare and the Basic Health Plan. Barlow Testimony, Tr. 2475:23-2476:12. Premera previously recognized that, because public pay programs generally do not reimburse providers for the costs of the services provided and in order to maintain a viable health care system, commercial insurance had to subsidize the public-pay programs by making somewhat higher payments to providers in order to cover some of the unreimbursed cost of the public programs. Ancell Testimony, Tr. 810:5-12; Barlow Testimony, Tr. 2481:12-14. In negotiating with providers, Premera also



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had the historic practice of assisting in maintaining the viability of rural hospitals. As Leo Greenawalt testified, "So in rural Washington, in earlier times, whenever Blue Cross was at the table, it was how do we make sure these communities get served. That was the first question, and they worried about that." Greenawalt Testimony, Tr. 2259:2-5.

Since 1997, however, when it hired the Goldman Sachs investment banking firm to advise it regarding means to raise capital, the company has had a business philosophy of requiring each line of business to be profitable within the reasonably near future. Barlow Testimony, Tr. 2485:15-2487:2. Consistent with this philosophy, it has decided to exit the Medicaid, Medicare, State Employee and Basic Health Plan lines of business. Paralleling the statements of Wellpoint's CEO quoted in the Larsen report, it has also expressly disavowed "cross-subsidization" of unprofitable lines of business. Ancell Testimony, Tr. 814:18-25.[6] And the company has adopted a "take it or leave it" attitude in contract negotiations with Washington providers – especially rural and Eastern Washington providers. Collins Testimony, Tr. 1826:2-14.

If, as a result of its changed philosophy and mission, Premera were to follow the lead of other for-profit Blues seeking to generate return for investors by lowering the amount it pays in patient care costs as a percentage of premium revenue, the burden on our citizens would be staggering. Premera's current medical-to-cost ratio is 84 percent, nearly identical to the rate for other nonprofit Blues established in the Carl Schramm report. *See* Barlow Testimony, Tr. 857:23-858:4. As applied to Premera's reported annual premium revenue of $2.05 billion in 2003, a percentage reduction in medical payments similar to the average found in the Schramm report – from 84 percent to 74 percent – would lead to a $205 million annual reduction in payment for health care.

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[6] Mr. Ancell testified that "The other thing is that [providers] are asking us to support Medicare and Medicaid, and we cannot continue to ask our subscribers to increase – today it is true that we subsidize those programs. But there has to be a limit to which we subsidize those programs, because every time we increase our premiums, more people can't buy insurance, and that's what happens if we continue to subsidize those programs." Ancell Testimony, Tr. 814:18-25.



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There is good reason to fear that this phenomenon will take hold in Washington if Premera is allowed to convert. As Premera's CEO testified during rebuttal, going public will bring new pressures to bear on the company: "[A company] that go[es] public where its performance is going to be closely monitored by the public markets out there to an extent that it has never experienced in the past...." Barlow Testimony, Tr. 2473. Or as Professor Jack Needelman of the Harvard School of Public Health has written: "Once you become a for-profit entity and take on public equity capital, especially in a high-growth industry, you cannot decide to reject the 'grow or go' imperative because your investors fully expect earnings growth of 15 percent or better, year after year." Jack Needleman, *Nonprofit to For-Profit Conversions by Hospitals and Health Plans: A Review*, Pioneer Institute for Public Policy Research available at http://www.pioneerinstitute.org/research/whitepapers/wp5.cfm (visited 5/25/04) (copy attached hereto as **Attachment C**).

In addition to the reasonably likely reduction in its rate of spending for healthcare in this state, Premera's conversion to a for-profit plan could cause several other negative effects that would harm the public interest. One impact is the effect conversion could have on consumers' access to insurance coverage. A converted Premera would likely become more aggressive in using underwriting[7] and benefit design[8] to avoid or manage costs. *See* Katz Testimony, Tr. 2296:24-2297:16. It would also likely increase premiums in its quest to generate profits for its shareholders. *See* Katz Testimony, Tr. 2299:11-2300:1; *see also* Ex. I-54 at 19. Both of these actions would negatively affect consumers' access to health care

[7] As a for-profit company, Premera might toughen the standards for qualifying for a particular type of coverage. For example, after converting to a for-profit organization, BCBS of Missouri eliminated individual coverage for the relatively low-cost Farm Bureau's association plan, moving its members to individual policies or to the Missouri high-risk pool. That decision meant that premiums doubled or tripled for hundreds of members. *See* Katz Testimony, Tr. 2297:25-2298:14; *see also* Ex. I-54 at 21.

[8] It is possible for converted health plans to use product design to promote favorable selection that ultimately leaves some sicker people without coverage. For example, health plans could choose to create low-cost, high-deductible policies, which tend to attract healthy individuals. This leads to higher premiums for lower-deductible policies (with fewer healthy people in those risk pools), and eventually to more uninsured people. *See* Katz Testimony, Tr. 2298:20-2299:10; *see also* Ex. I-54 at 21-22.



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insurance. *See* Ex. I-54 at 18-25. Also, a converted Premera would be tempted to further withdraw from unprofitable markets in order to maximize benefits to shareholders, which would create access problems. The could devastate access for low-income, rural, small group, and non-group coverage individuals, especially those with significant health care needs (such as people with disabilities, and those who are disproportionately uninsured, such as people of color). *See* Katz Testimony, Tr. 2301:11-2302:6; *see also* Ex. I-54 at 24.

A second concern is a potential reduction in community benefits if Premera's proposed conversion is approved. Available information suggests that non-profit health plans are more likely than for-profits to provide community benefits. *See* Katz Testimony, Tr. 2303:11-2304:9; *see also* Ex. I-54 at 27-28. Community benefits are those benefits that accrue to the larger community as a result of an organization's activities, beyond the specific goods or services that the organization provides. In other words, by definition, community benefits do not directly contribute to an organization's bottom line. This means that an investor-owned health plan would likely be less focused on such activities. *See* Ex. I-54 at 27-28. For example, a converted Premera would be less likely to engage in "subsidizing community health promotion programs or safety net services and the like." Katz Testimony, Tr. 2303:13-20. Indeed, Premera seemingly intends to leave such endeavors to the foundations in the future.

Finally, the likelihood that a converted Premera would be bought by a national company leads to a host of other harmful effects.[9] Experience and theory suggest that a national for-profit health plan will tend to focus more on the national market and less on the unique characteristics of the local markets, consumers, and providers in Washington. *See* Katz Testimony, Tr. 2304:10-2305:7. This could also result in (1) more contentious

[9] The possibility that a for-profit Premera would be acquired by a national plan is not mere speculation. The fact is that most converted Blues plans have been bought by one of two national purchasers – either Anthem or WellPoint – concurrent with or shortly after conversion. *See* Katz Testimony, Tr. 2304:14-25; *see also* Ex. I-54 at 28.



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interactions with local providers over contract terms and payment issues, (2) a loss of local jobs and a decrease in service levels as state-based service centers are moved to national locations, and (3) a decrease in Premera's involvement in local health policy discussions, as a national health plan would be less likely to expend political resources to support local health care initiatives. *See* Ex. I-54 at 28-35.

**1. Premera's position in the market and its behavior during the "ramp-up" to conversion is predictive of the adverse effects likely to result from Conversion.**

Premera's current market position and the behavior that it has exhibited during the last seven years indicate that it has been trying to favorably position itself for an IPO further confirm that adverse impacts on Washington's health care consumers are a likely result of conversion.

a. Premera has market power in Eastern Washington

Premera is the dominant commercial payer in Eastern Washington, so dominant that even large national carriers have tried and failed to gain market share there. As the testimony showed, NYLCare, United Health Care, QualMed, and the Sisters of Providence have left the market entirely; CIGNA has less than one percent of the market, and Aetna has 1.28 percent of the regulated market. McCarthy Testimony, Tr. 555:19-22; 610:12-14; 616:7-10; 616:20-24; 619:24-25; 620:5-7; 620:9-16. Indeed, the OIC Staff experts estimated that Premera has an approximately 90 percent market share in individual and small group coverage in Eastern Washington. Leffler Testimony, Tr. 1763:15-21. Despite many years of trying to build its customer base, Regence has a mere 9,000 members in Eastern Washington. McCarthy Testimony, Tr. 559:13; 560:1-8. This meager share should come as no surprise: Blues Association rules prevent Regence from using the Blues mark in that part of the state.

The dearth of true competition in Eastern Washington is reflected in Dr. Jeff Collins's practice. Over half of his patients with commercial insurance are covered by Premera. Collins Testimony, Tr. 1818:12-25. The next largest carrier in his practice, PHCO, has a



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mere 5 percent of the total, a tenth of what Premera has. Collins Testimony, Tr. 1819:1-13. His experience is not an aberration: Dr. Collins stated that most of his colleagues in the region are in a similar situation. Collins Testimony, Tr. 1819:18-20.

In the face of this evidence, Premera contends that the relevant healthcare market should not be limited to Eastern Washington, but expanded to encompass the entire state. Premera Exhibit P-22: Antitrust and Economic Impact Analysis of the Proposed Conversion of Premera Blue Cross in the State of Washington, November 10, 2003. By including the more competitive Western Washington market in its definition of marketplace, Premera makes a clumsy attempt to have its market dominance in Eastern Washington appear less significant. This claim should be accorded little weight.

To begin, the OIC experts simply do not agree with Premera's definition. Leffler Testimony, Tr. 1756:17-25; 1757:1-25; 1758:1-6. Nor does common sense: residents of Eastern Washington do not routinely receive care in the Western part of the state. They do so only in the rare instances where such care is not available more locally. Conversely, physicians in Eastern Washington do not see patients from the Western part of the state absent extraordinary circumstances. Unlike Western Washington, where the population is densest along the I-5 corridor, the population in Eastern Washington is widely dispersed, with relatively few physicians.

Just as Premera erroneously maintains that the two markets are really one, it deploys equally suspect logic to argue that it faces robust competition. Premera insists, for example, that Regence is a vigorous competitor in Eastern Washington, Donigan Testimony, Tr. 696:19; McCarthy Testimony, Tr. 617:8-16, but then repeatedly asserts that Premera itself would lose a huge competitive advantage if it were forced to relinquish the Blues mark. Milo Opening Statement, Tr. 25:17-19; Barlow Testimony, Tr. 125:18-21; 128:10-13; McCarthy Testimony, Tr. 618:2-8. Premera also exaggerates the level of competition by mentioning carriers that are only in limited geographic markets (such as Kaiser, available only to certain



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residents in the Vancouver area), or in limited product markets (such as Molina and Community Health Plans, that offer coverage exclusively in public programs, which Premera no longer does), or companies that are not health insurers (such as First Choice Health Network, PHCO, and NorthwestOne, all of which are PPOs). Inflating the minor roles these companies play enables Premera to conclude that it does not exercise undue market power.

The credibility of such a conclusion can be measured not only by the data that went into it, but by who was performing the analysis. Premera's expert admitted he had only handled one brief, uncontested case in our state before, that he has never set foot in Eastern Washington, and that he did not speak with a single physician, hospital, or Premera competitor in doing his evaluation of Washington's health care marketplace. McCarthy Testimony, Tr. 605:6-25; 606:1-25; 607:1-5. For these reasons, his conclusions are entitled to no weight.

b. Premera's Current Market Power makes Premium Increases likely if Conversion is allowed.

Conversion will likely lead to premium increases by Premera in the individual and small group markets in Eastern Washington. Based upon the information provided by Premera, PricewaterhouseCoopers determined that under Premera's current projections, the company will not meet "market-based expectation that most lines of business should attain target operating margins." Exhibit S-20, ES-5; 66-69. In order to meet market expectations, Premera would have to "either attain greater savings in health care costs or administrative expense or to increase premiums." Exhibit S-20, ES-6. The experts determined that Premera may be able to increase its operating margins in the individual and small group markets in Eastern Washington. *Id.* "Rate increases of as much as 8-10% above expected trend for some lines of business in some geographies will be required to meet Premera's goals." *Id.* The OIC experts' analysis indicated that premium rates could rise on average as much as $300 per person per month, for an estimated 96,800 people in Premera's eastern Washington individual



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and small group markets, by 2007. Exhibit S-20, at 92. Premium increases would not only cause significant financial hardship to the eastern Washington individuals, families and small businesses impacted; the increases would also impact the rising rate of uninsurance in Washington state. Exhibit I-54, at 18-25; S-31, at 71-72.

Given shareholder demands, it is reasonable to assume that a for-profit Premera would be forced to increase its profits by raising premiums where it can. Although Premera argued at the proceeding that it did not intend to change the way it sets rates for the individual and small group markets, as Mr. Staehlin testified, "...people change. Premera is not a person. It is a board of directors. It is a lot of people and there could be different people, different facts and circumstances." Staehlin Testimony, Tr. 1871:13-16. Post-conversion, such premium increases could happen without prior approval by the Insurance Commissioner, and could harm Premera's eastern Washignton enrollees and the public interest. *See* Exhibit S-31 at 69-72 (citing to the Kansas Blue Cross case, "the Commissioner is not required to wait until likely future harm to the public appears before locking the barn door; she may do so now as a preventative."); S-33, 87-88. *See also* Exhibit I-54, at 19-20 (discussion of effect of conversion on premiums).

Premium increases have a direct impact on patient care. Dr. Collins testified that when premiums rise, patients tend to defer care or seek care over the telephone. Collins Testimony, Tr. 1831:1-2. They also are less likely to comply with the recommended treatment. Collins Testimony, Tr. 1831:2-6. Too often, patients wait to seek care until they are so sick that they have no choice, and too often they end up in the emergency room. Perna Testimony, Tr. 2155:14-19. While Premera was increasing physician reimbursement a mere 4.7 percent on average per year, it hiked premiums in the individual market an astonishing 90 percent and premiums in the small group market over 50 percent during the same period. Barlow Testimony, Tr. 2495:9-25; 2496:12-19.



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c. Premera currently uses its market power to the detriment of subscribers; a Requirement to Generate Profits can only exacerbate these Hazardous Effects.

Premera's dominance has already caused great harm to consumers, and to the physicians and hospitals that care for them. Indeed, substantial evidence in the record shows how Premera has used its market power in a manner that is unfair to subscribers and is against the public interest – especially in regard to access to care and payment for medical services. And substantial evidence shows how conversion will likely make that worse.

One of the most important ways Premera inhibits access to care is through its interference in the medical judgment of physicians. Dr. Collins described the recent, representative example of how Premera denied treatment for a patient who was suffering from loss of muscle mass and bone density. Collins Testimony, Tr. 1820:6-23. He eventually convinced Premera to reverse its denial, but only after he expended a lot of time and effort, time and effort that would be better spent on his patients. Collins Testimony, Tr. 1821:1-6. All of the administrative barriers to care erected by Premera, even when they can be overcome, represent an enormous diversion of physician time away from patient care. Collins Testimony, Tr. 1819:21-25; 1820:1-5. Perna Testimony, Tr. 2145:6-8; 2149:21-25. A related way that Premera inhibits access is through the wrongful delay or denial of authorization for tests, procedures, and medications.

Premera wants the Commissioner to believe that these are problems of the past, and that its new approach shows that the interests of patients and providers matter to the company. Ancell Testimony, Tr. 796:10-25; 797:1-5. As proof, Premera offers its "voluntary benefit advisory", which supposedly will do away with the requirement for prior authorization. As Mr. Perna explained, the "advisory" could make a bad thing worse, since there is no guarantee of promptness or payment. Perna Testimony, Tr. 1850:4-9. Dr. Collins testified that he is still awaiting a reply to his "advisory" request, weeks after it was promised, and weeks after it was initially denied – by someone who was not even a physician. Collins Testimony, Tr.



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1823:16-25; 1824:1-17. The inability to get a fast or reliable answer about what care is authorized is an endemic problem with Premera, according to Dr. Collins. Collins Testimony, Tr. 1822:2-17. He recalled the common refrain he hears from company personnel, such as "our computers don't talk to each other" and "I don't have the authority to make that decision." Collins Testimony, Tr. 1822:17-25.

While the company proclaims it has an open formulary, in practice it is open only to those who can afford it. Dr. Collins expressed his frustration that Premera forces patients to pay more for certain medications, even when patients suffer side-effects from its "preferred" medications. Collins Testimony, Tr. 1825:1-11. Drugs appear on Premera's preferred list not for clinical considerations but because the company extracts a better price from the manufacturer. Collins Testimony, Tr. 1825:1-8. Requiring patients to pay more is tantamount to denying or reducing the use of needed medications for all too many patients, Dr. Collins testified, particularly the sickest, oldest, and poorest patients, who are most likely to be using multiple medications and have multiple conditions. Collins Testimony, Tr. 1845:6-25; 1847:1-3. Premera did not, and could not, contradict Dr. Collins's account of what it is actually like to deal with the company, nor did it rebut his insights into Premera's drug-pricing strategies.

A disturbing new development is that care and coverage decisions are increasingly not being made by Premera personnel in Eastern Washington, but rather at company headquarters. Perna Testimony, Tr. 2148:1-7. The fear among physicians is that, as a for-profit, Premera would accelerate the centralization of care decisions in the name of "efficiency", far away from where the need is, and farther still if conversion leads to acquisition by an out-of-state carrier. Perna Testimony, Tr. 2148:8-25. This is not mere speculation: while physicians consistently regard Premera as among the worst insurers to deal with, out-of-state carriers are regarded as worse still. Perna Testimony, Tr. 2148:17-25; Collins Testimony, Tr. 2149:1-4.



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Of course, one of the significant measures of access to care is whether physicians will be there when a patient needs them. Premera's reimbursement policies have already put physicians' ability to continue to see patients in peril. It does so by refusing to negotiate its fees. Premera conceded that 70 percent of all physicians in Eastern Washington, and 66 percent of physicians statewide, are forced to accept what it euphemistically calls a "standard" contract, but what Premera has privately told physicians is a "take it or leave it" contract.[10] Even Dr. Collins, who practices with twenty other physicians at one of the largest clinics in the region, has no choice but to accept Premera's terms. Collins Testimony, Tr. 1826:2-14. Most physicians are in the same bind: what practice could afford to turn away one-third to one-half its business? Collins Testimony, Tr. 1826:2- 7.

Inadequate reimbursement is already having an impact on our state: Mr. Perna noted that physician recruitment and retention has become harder, as the pay in other states is far better. Perna Testimony, Tr. 2153:11-25; 2154:1-4. At the same time, Washington physicians are retiring at a record rate, and at an earlier age. Perna Testimony, Tr. 2154:5-11.

These trends pose a looming threat to the quality of patient care in Washington. The immediate byproduct of inadequate reimbursement is that physicians and hospitals can no longer afford to care for the uninsured and underinsured patients as they have in the past. Dr. Collins's own clinic had to limit the number of poor patients it treats, as have so many other providers across the state. Collins Testimony, Tr. 1845:14-23; Perna Testimony, Tr. 2151:22-25; 2152:1-4. Those patients then end up in the hospital emergency room, needlessly suffering and costing taxpayers and policyholders more money. Collins Testimony, Tr. 1831: 1-6.

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[10] The Commissioner's public hearings in Eastern Washington are replete with provider testimony regarding the "take it or leave it" stance Premera takes in negotiations. One hospital administrator in Central Washington described how Premera rejected his overtures to renegotiate the terms of the contract and demanded the hospital accept a 30 percent reduction in payments. Premera's representatives told the administrator, "You really can take this or leave this. It doesn't matter to us." Williams Testimony, Yakima Public Hearing (Dec. 4, 2003), Tr. 55:3-56:8.



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If Premera becomes obligated to maximize profit to benefit its shareholders (as it undoubtedly must do if this conversion is permitted), physicians, hospitals, and consumers fear that Premera would:

- Accelerate the use of less expensive, but less qualified, non-physicians to conduct medical reviews of physicians' care decisions. Ancell Testimony, Tr. 864: 12 -22, 866: 2 – 21.
- Delay or deny provider requests for needed tests, procedures, and medications, especially since such expenses consume 84 percent of Premera's revenue. Premera Exhibit 90. Administrative barriers and inadequate reimbursement have very tangible, effects on patient care.
- Drive reimbursement for medical services down even further, threatening the viability of medical practices and forcing others to turn away the poorest and sickest patients. Perna Testimony, Tr. 2151:18 -25; 2152:1-4, 12-20.
- Abandon unprofitable lines of business. Providers have already seen what happens when Premera withdraws from a market: when Premera stopped issuing new coverage in the individual market, many people who could not find or afford replacement coverage, leaving them more vulnerable at a time of great need. Perna Testimony, Tr. 2154:16-25; 2155:1-2, 14-19.
- Abandon unprofitable geographic areas of the state. Eastern Washington is sparsely populated and doesn't have the economies of scale that insurers seek. Premera claims that network adequacy regulations would act as a sufficient safeguard against such an occurrence, yet had to admit upon cross-examination that the only network adequacy standard it has to meet is one set by itself; nor could it deny that there has never been any punishment for failure to meet such a standard. Ancell Testimony, Tr. 826-829.

Premera introduced no evidence that it would be able to satisfy investors purely through administrative efficiencies, nor does it make sense that Premera would be able to generate profits through increased efficiencies that no other health carrier has been able to achieve. Exhibit S-31 at 67; *See* Exhibit I-54 at 16 ("Plans proposing to convert argue that new capital will allow them to grow in size and realize economies of scale, but size doesn't not necessarily lead to lower administrative costs"). Given the necessity of paying premium taxes, brokerage commissions, and the overhead inherent in insuring millions of lives, the largest, most tempting target for increasing revenue would be premiums charged to patients or cutting and delaying payments to providers.



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For all of these reasons, there is substantial evidence in the record that demonstrates that Premera has market power in Eastern Washington and post-conversion would operate in a manner that is unfair and unreasonable to subscribers and likely to be prejudicial to the public interest. There is ample evidence that Premera already exploits its market position in Eastern Washington; if Premera were to become for-profit, its shareholders would demand even greater returns, and its corporate behavior will very likely become even worse.

## III. THE CONFLICTED INTERESTS OF MANAGEMENT AND THE ABSENCE OF PERSUASIVE REASONS FOR CONVERSION ARE FURTHER GROUNDS FOR DENIAL UNDER THE HOLDING COMPANY ACTS.

Under the Holding Company Acts, the Commissioner must consider whether the "competence, experience and integrity" of Premera's management and board are such that it would not be in the interests of policyholders and the public to permit the proposed transaction.[11] RCW 48.31B.015 (4)(a)(v); 48.31C.030(5)(a)(ii)(C)(III). The OIC experts and Premera agree that this provision requires a consideration of the company's board and executive compensation plans both before and after conversion, as reflected by the expert reports submitted by both parties. *See* Exhibits P-51, P-52, S-27, S-28. The Commissioner should consider whether the integrity of Premera's board and management is called into question by the excessive compensation offered in preparation for conversion and post-conversion. Based on the OIC Staff's expert's findings, Premera's executive compensation appears to have been "ramped up" in anticipation of conversion, and the financial benefits to the Premera board and executives post-conversion, rather than the public interest, appear to have influenced the company's decision to convert.

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[11]When considering the integrity of Premera management, the Commissioner should also consider whether Premera management actively misrepresented it's intentions related to conversion when it submitted correspondence to the state legislature stating that the company had no plans to convert to for-profit status and "the issue of conversion is not even under consideration by the company." Exhibit I-3. At the time Premera wrote this letter, it had already obtained preliminary advice from Goldman Sachs regarding conversion, and was taking steps in accordance with an apparent long-term plan to convert; yet Premera management failed to divulge this information to the legislature, to the Insurance Commissioner and to the public. *See* Exhibit I-5, page 2; Barlow Testimony, Tr. 2483:6-19.



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## A. Premera's current executive compensation is significantly "above the market."

Undisputed facts in the record shows that Premera's current, pre-conversion executive compensation is generous: Premera executives make significantly more than their nonprofit peers in Washington State.[12] Exhibit I-74 at 5. Premera's executive compensation is "above market practice" when compared to Premera's Blue Cross and Blue Shield peers. Exhibit S-27 at 7, Testimony of Donald Nemerov Tr. 1597, lines 13-19. In fact, according to experts, the only circumstance in which Premera executives do not make more than their peers, is when Premera's compensation expert construed a peer group flooded with companies that represent many large non-Blue for-profit corporations from other parts of the country. *See* Nemerov Testimony, Tr. 1595:21-1596:2.

According to OIC experts, it is hard to account for the above-market compensation packages currently provided to Premera's top executives. As Mr. Nemerov testified, the valid reasons for which a company might pay above the market level may be (1) if the company is a high performing company when compared to its peers; or (2) if higher compensation is needed to attract and retain talented staff. Nemerov Testimony, Tr. 1598:22-1599:17. Mr. Nemerov testified that neither circumstance is in place for Premera. The company is not performing as well as its peers and retention of top management is not currently a problem for the company. Nemerov Testimony, Tr. 1599 :3-1600:1.

Why would a nonprofit local health insurer need to offer compensation above the market? As Mr. Cantilo testified, "Premera seems to have been very well prepared for this conversion and has learned a lot from the preceding ones." Cantil Testimony, Tr. 2116:18-22. Much attention has been paid to executive compensation in conversion transactions; a company with a long-term plan to convert might try to gradually increase salaries to where

[12] Premera's compensation expert, Richard Furniss, testified that he would compare the compensation of Premera's CEO to the CEO of Regence, the holding company parent, rather than to the CEO of Regence of Washington, as was done in Exhibit I-74. Furniss Testimony, Tr. 790:10-18. Interveners' disagree with that analysis; nevertheless, the compensation packages of Premera's top executives, other than CEO, are significantly higher than that of their Washington state nonprofit colleagues.



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they are comparable to that of for-profit corporations, in order to avoid the appearance (but not the effect) of "unjust enrichment" immediately after the conversion.

**B. <u>The promise of lucrative stock options to the Premera management and board post-conversion may have influenced the decision to convert.</u>**

After conversion, Premera's board and top executives would have stock options in addition to their already generous compensation packages. Nemerov Testimony, Tr. 1609, lines 15-21. The executives need wait only one year until they receive stock options, post conversion. Furniss Testimony, Tr. 746:20-747:9. Further restrictions on the provision of stock options contained in the Premera Compensation Assurances are only in place until three years post-conversion. Revised Form A, Exhibit E-8, Compensation Assurances. After three years, Premera's executives could see their compensation skyrocket further. If past conversions are any guide, these executives stand to make multi-millions if they wait out the promised "assurances." *See generally* Exhibit I-75, "*How Much is Too Much? Executive Compensation Following the Conversion of Blue Cross and Blue Shield Plans from Nonprofit to For-Profit Status.*"

Premera's Board will also be awarded stock options, in addition to their current compensation. Neither Premera nor the OIC experts analyzed the impact of the conversion on Board compensation, although the Mercer Report indicates that, with the addition of stock options, Board compensation could triple. Nemerov Testimony, Tr. 1590:3-15; Furniss Testimony, Tr. 771:13-21. Neither expert considered whether the Premera board, both before and after conversion, is compensated at a rate out-of-line with its non-profit or even for-profit peers. Stock options are valuable, and cannot be disregarded when considering executive compensation, despite Premera's arguments to the contrary. Furniss Testimony, Tr. 753:7-20. Premera's own Mercer Report assigned a value to the options that the Premera Board proposes to grant to its top executives. Furniss Testimony, Tr. 770:2-6. Moreover, as testified to by Jonathan Koplovitz, stock options do have a real, present value – a value that is



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widely recognized, can be traded in the market, and can be expensed on a profit and loss statement.[13] Koplovitz Testimony, Tr.1382:13 to 1383:4. Premera's position that stock options have no value makes no sense. After all, if the options were valueless, then they would not be the one of the most effective methods for aligning the interests of executives and shareholders.

Cantilo and Bennett's reports indicate that the transaction itself may be motivated by factors such as top management's expectation of stock options, increased salary or other compensation as a result of the conversion. Exhibit S-31, at 88, 91; Exhibit S-33 at 89. Indeed, according to the OIC's experts, it is hard to understand how the prospect of significantly increased compensation could not have an impact in the decision to convert. As Mr. Nemerov testified, "Certainly the opportunity to have a benefit like [stock options] would, of course, be a very powerful inventive to convert." Tr. 1649:6-14. Moreover, the decision to convert may have been influenced by the Board's impression that it needed to provide stock options to current management in an effort to retain them. Evidence exists that the Board considered "management retention" as a benefit to conversion. *See* Exhibit S-31, at 91 (describing a presentation to the Premera Board that included statements that "career growth opportunities" and "long term incentive" were advantages for Premera to convert to a for-profit company).

[13] Premera's expert testified that "[s]tock options provide perhaps the purest form of linkage between executives – maybe some people think it is the purest – between executives and employees and the shareholders." Furniss Testimony, Tr. 750:2-5. If nothing else, the issuance of stock options to top management and the board demonstrates how the mission of the corporation will change post-conversion. Now, top management will have a direct financial benefit if the company meets shareholder expectations for significantly more profit. These incentives will push Premera management to a much greater extent than they have experienced while running a nonprofit company, to ensure ever increasing profits. Currently, no line of business at Premera (except its Medicare Supplement program) is projected to achieve its target operating margins. Exhibit S-20, at 66. As a for-profit, shareholders will demand that these targets be met, and the Board and top executives need to respond by changing the way the company does its business.



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## C. Premera's unusual Change in Control benefits provide an additional financial incentive for the company's later acquisition or merger.

The Premera compensation package includes "highly uncommon" and exceedingly generous change of control benefits for top executives. Exhibit S-27 at 27. Under Premera's compensation plan, top executives have "walk-away rights" which provide top management extra benefits should they leave the company within one year after a merger or acquisition. *Id.* *See also* Nemerov Testimony, Tr. 1602:11-20. The OIC Staff experts have estimated the value of the Change in Control benefits to be approximately $22.5 million.[14] Exhibit S-27 at 26.

Premera attempted to justify these special benefits for top management by stating that it was important for the entire management team to stay on board after a merger for up to a year. Furniss Testimony, Tr. 766:8-16. However, even Premera's expert admitted that these benefits are "unusual" for executives other than the CEO. Furniss Testimony, Tr. 781:15-17. Normally these benefits are only conferred upon a CEO, rather than an entire top management team. Exhibit S-27 at 27. The fact that the entire top management team has "walk away rights" could indicate that a later merger or acquisition is extremely likely, if not assured. These financial benefits appear to be an additional incentive for top management to steer the company towards a merger or acquisition, mostly likely by Wellpoint/Anthem. *See* Cantilo Testimony, Tr. 2129: 23-2131:10:

> Q: In the case of management and what I think would apply here as kind of a golden parachute, would it be a stronger golden parachute if they were to do a merger or acquisition as a part of conversion or to do it afterwards, after they've converted to a public company?
>
> A: Well, based upon my experience, far, far more lucrative after. I think the senior managers and senior shareholders of Trigon, for example, who were with Trigon up until the time it was acquired by Anthem, have done far better

[14] No analysis of the value of the Change in Control benefits was conducted by Towers Perrin, Premera's executive compensation experts. Tr. 765: 1-15.



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by selling themselves to Anthem after they were publicly traded than they would have done if they had sold directly to Anthem back in '98 when they converted, if that's responsive to your question.

## IV. NEITHER PREMERA'S "ASSURANCES" NOR THE PROPOSED WASHINGTON FOUNDATION MITIGATE THE LIKELY HARM TO THE PUBLIC INTEREST.

As the testimony from the OIC's experts made clear, Premera's various assurances do nothing more than delay the adverse consequences of conversion. *See* Staelin Testimony, Tr. 1915:3-5. A temporal limitation is not a problem solving approach; it is a problem delaying tactic. An adverse impact on the public interest two years from now is still an adverse impact. The only way to truly avoid the harm to the public is to deny the application.

Ironically, that Premera would even offer limited assurances suggests that it tacitly acknowledges the potential harms that may arise. The limited nature of those assurances is also suggestive of the very real possibility that once the limitation has expired, the harmful conduct will follow. Likewise, any grants from the charitable foundations cannot reasonably be expected to make up for the loss in payments for healthcare that are reasonably likely to occur if conversion is allowed. *See* Katz Testimony, Tr. 2306:14-2307:8 ("I don't think the creation of a foundation or the activities or the programs or services that it would fund are a salve to whatever problems might arise.").

To begin, the foundations are not intended to make up for reduced healthcare payments or to fund health insurance coverage for the uninsured or underinsured. Dingfield Testimony, Tr. 269:11-18. Moreover, based on the information submitted by Premera, both foundations could be expected to pay out around $25 million in Washington and Alaska.[15] Grants in this amount would be a veritable "drop in the bucket" as compared to the shift of

[15] Although Premera has never publicly stated how much it anticipates that the proposed foundations will pay out annually in grants, according to Premera's Exhibit 216, at p. 2358, foundations resulting from conversions of hospitals and health plans nationally have total assets of $15.3 billion and an annual grant potential of $752 million, that is, 4.9 percent of the total assets. Applying this rate to the proposed foundations' estimated assets of $500 million obtains the result of $24.5 million in annual grants.



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fund from payment to healthcare to payment to investors that can reasonably be expected to occur if conversion is allowed.[16]

The insufficiency of foundation grants is compounded even further by several inherent flaws in the structure of the foundations themselves. Indeed, the foundations, as proposed, are simply not in the public interest. First, approval of Premera's application will not lead to the prompt funding of a foundation to benefit Washington residents. As the expert opinions submitted by OIC Staff and the Alaska Division of Insurance suggest, any approval without resolution of the allocation dispute may spur massive litigation between the states of Washington and Alaska. The Commissioner is essentially being asked to approve a conversion that has known adverse consequences, without knowing the full value of the purported benefit that could accrue to Washington. That decision – which could be years away – would likely be left to judges and appellate courts in Washington and/or Alaska. This uncertainty and delay, with its associated costs, does not serve the public interest.

Second, the proposed foundations are unduly constrained from advancing important health initiatives. The public interest is not served by a foundation that is, by design, hamstrung. It is naive to believe that Premera has proposed an independent and autonomous structure. As proposed, the Washington foundation would be precluded from any activities deemed "materially adverse" to the interests of health insurers. As proposed, the Washington foundation would be precluded from any activities deemed "materially adverse" to the interests of health insurers. Exhibit. S-33 at 85 - 86 (Supplemental Report of Cantilo &

[16] As Duane Dauner testified, California's WellPoint reported its first quarter profits for 2004 to be $295 million, which, over an annualized basis, will amount to approximately $1.2 billion – or $7.50 a share. Tr. 2269:2-10. According to Mr. Dauner, "If you think about the numbers, just the sheer numbers, if that money that is going to $7.50 per share, was going into services in California, as opposed to profits paid out per share, we would see that we are talking about hundreds of millions of dollars a year. And when you think about what a 1 or 2 or 3 or 4 billion dollar foundation can give in philanthropy, it pales in comparison.... The foundations that give philanthropy are giving in the hundreds of thousands or a few million, and in some cases, they may even give in the tens of millions. But that is a small proportion – very miniscule – compared to the hundreds of millions that are going out for profits -- that are coming from the patient or from the employers and individuals that are paying premiums for healthcare." Tr. 2269:11-2270:3.



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Bennett). Premera, in fact, retains the ability to sue the foundation or its grantees for their activities. As Mr. Benbow testified, such restrictions would undoubtedly have a "chilling effect" on the activities of the foundation and the grantees. Benbow Testimony, Tr. 2338:14-2339:1; Tr. 2340:2-17.

By precluding activities that are "materially adverse" to the health insurance industry, Premera has proposed an unprecedented restriction. Benbow Testimony, Tr. 2339 lines 2-4. There is, for example, no such restriction in the California Foundations, *see* Reid Testimony, Tr. 327:6-9, and no agreement that would allow Wellpoint to sue the foundations or its grantees. Reid Testimony, Tr. 327:18-23. As Mr. Reid explained, the issue never even came up when he served as the lawyer for the two California Foundations and as a board member of the California Endowment. Reid Testimony, Tr. 322:22-323 :5. In fact, the California Endowment has funded advocacy efforts that could be considered "materially adverse to the interests of health insurers." Reid Testimony, Tr. 323:6-324:10 (discussing the Health Rights Hotline).

As proposed by Premera, the foundation would be prevented from participating in many important health efforts. It could be prevented from establishing or funding a health insurance rights hotline, even if such a resource was deemed to be a critical need for the state by the foundation. Premera also would be free to, for example, seek the repeal of Washington's Patients Bill of Rights or other important legislation that affects health insurers without fear of foundation or grantee intervention. Moreover, if the foundation determined that it was in the best interests of the state to require that insurers cover certain forms of preventive care, it could do nothing without fear of being sued by Premera.

That fact of the matter is that many important health initiatives could very well be construed, by Premera, as adverse to the interests of health insurers. An emasculated foundation, unable to participate in significant segments of the health care system, is not in the public interest.



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Third, the selection of foundation board members would not be independent. Premera should not be allowed to influence the composition of the foundation boards. The public interest is only served by a neutral and independent process – a process that does not exist in Premera's proposal.

A proper process should be completely independent; one that does not allow the 20 groups already identified by Premera to have any preference in the process. Benbow Testimony, Tr. 2341:14-24. A proper process would be "diverse, wide-ranging and non-bias[ed]." Reid Testimony, Tr. 325:8-16. The composition should not be restricted and Premera should not be allowed to disqualify entire groups because of pre-conceived notions about conflict-of-interest situations. As Barbara Dingfield testified,

> I think you can have anyone as a board member but you have to be very conscious of conflict-of-interest issues. And I think most of the Foundations that exist that are derivative from health care conversions have very clear conflict of interest provisions. So that does not mean someone cannot be a board member, but would have to recuse himself or herself when there are any issues that create conflict of interest[s].

Dingfield Testimony, Tr. 275:11-18. *See also* Benbow Testimony, Tr. 2341:25-2342:7; Cantrell Testimony, Tr. 2361:13-19. Premera's proposal is unduly restrictive. This restrictiveness, in turn, hampers the foundation's ability to perform its functions in an independent manner. This is not in the public interest.



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## V. REJECTING CONVERSION WILL PROTECT OUR NONPROFIT HEALTH SYSTEM AND WILL NOT HARM PREMERA, ITS SUBSCRIBERS OR THE PUBLIC INTEREST.

Rejecting Premera's conversion will not harm subscribers or the public. As many of Premera's witnesses readily admitted, Premera will be financially secure and productive if conversion is not approved. Jewell Testimony, Tr. 87:17-19. Premera will continue to make necessary investments to meet the needs of its customers. Barlow Testimony, Tr. 145:12-23. As a nonprofit, Premera has been able to dedicate approximately $125 million to the development and implementation of a new product, Dimensions. Barlow Testimony, Tr. 115 lines 10-13. The company has been able to grow by 38 percent since 1999. Barlow Testimony, Tr. 119:14-15. It has also been able to increase its RBC level, so that at the end of 2003, its RBC is at 433 percent.[17]

However, Premera's failure to be held accountable to its nonprofit mission does harm subscribers and the public. Premera has ceased to be true to its nonprofit purposes and mission. When considering conversion, the board apparently undertook no investigation into whether the action was in keeping with its current and historical nonprofit mission, and did not consider whether the company was a charitable corporation. *See* Jewell Testimony, Tr. 98:10-17. Even Kent Marquardt explained when looking at the Articles of Incorporation of Medical Services Corporation of Spokane County, one of Premera Blue Cross' predecessors, "It has been a little while since I read this one...." Marquardt Testimony, Tr. 1188:15-16. During the administrative proceeding, Premera repeatedly referred to its mission as "peace of mind for its subscribers," a meaningless purpose statement it developed in 1998 without any apparent reference to the corporation's current or historical nonprofit purposes. Barlow Testimony, Tr. 111:6-16.

[17]While Premera claims it must convert to increase its RBC to keep up with its peer Blue plans, other Blue plans with high reserves have been accused of hoarding reserves at the expense of policyholders, and are providing refunds to consumers. *See* Rhode Island's Got the Blues, Modern Healthcare, May 17, 2004, at http://www.modernhealthcare.com/article.cms?articleId=32610 .



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The company's current and historical mission is to serve the health care needs of working families, Exhibit I-7, Article 3 (a); Exhibit I-8, Article 3(a); and to serve and promote the general welfare of those who may become subscribers of the plan, Exhibit I-6, Article II. Unfortunately, its board and management appear to have strayed far from those purposes, seeking instead to emulate the practices of for-profit corporations. Premera's transfer of its Medicaid Healthy Options and Basic Health Plan contracts, (programs which served the low-income families in Eastern Washington that the Medical Services Corporation was originally formed to assist) is an example of how the company has forgotten its true nonprofit mission. *See* K. Song, "Premera wants to Transfer Health-care coverage for poor," *Seattle Times*, March 2, 2004 (describing Premera's transfer of these lines of business, despite their profitable nature); Marquardt Testimony, Tr. 1194 lines 8-9 (describing the Premera Healthy Options and Basic Health Plan lines of business as profitable). In fact, in Heywood Donigan's pre-filed testimony, no mention is made of the role that the corporation's nonprofit purpose has when the company determines whether to continue participation in a product line. Exhibit P-42, p. 4, lines 6-15.

As Steve Larsen testified, after the CareFirst conversion was denied, the Maryland legislature took action to ensure that CareFirst was more accountable to its nonprofit mission, one part of which involved a change to the current Board of Directors. Larsen Testimony, Tr. 2235:13- 2236:12. *See also* Chapter 356, Maryland General Assembly Acts 2003 (setting forth the mission of CareFirst as: (1) providing affordable and accessible health insurance; (2) assisting and supporting public and private health care initiatives for persons without health insurance; (3) promoting the integration of a statewide health care system that meets health care needs) and Chapter 357, Maryland General Assembly Acts 2003 (establishing an oversight committee and a nominating committee for CareFirst; requiring a nonprofit health service plan to offer health care products in certain markets in Maryland; establishing maximum compensation fee limits for Board members; requiring the establishment of



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executive compensation guidelines by the Insurance Commissioner and prohibiting conversion or acquisition for five years.). The Maryland Blue Plan flourished during the period after its conversion was rejected. Larsen Testimony, Tr. 2236:18-24; *See also Rhode Island's Got the Blues*, Modern Healthcare, May 17, 2004, at http://www.modernhealthcare.com/article.cms?articleId=32610 (CareFirst's net income increased 64 percent after rejection of its conversion application). Similar legislation is under consideration in Rhode Island, and perhaps other states. *Id.*

## V. CONCLUSION

In Washington State, we can do better than try to "unring the bell". By denying Premera's conversion request outright, the Commissioner can prevent the for-profit takeover and transformation of our health system that would result from the conversion. We can ensure that our health system stays nonprofit and that Premera returns to serving its true nonprofit mission and purposes. As the experience in Maryland reveals, holding the company accountable to its mission need not come at the expense of current subscribers or the company's continued success. It is not too late to ensure that Premera returns to its roots to be a nonprofit, mission driven, community-focused company.

DATED this 28th day of May, 2004.

By _____
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# ATTACHMENT A

No. 02-89075-AS

IN THE SUPREME COURT OF THE STATE OF KANSAS

BLUE CROSS AND BLUE SHIELD
OF KANSAS, INC.,

Appellee/Cross-Appellant,

v.

KATHLEEN SEBELIUS, in her official Capacity
as Commissioner of Insurance for the State of Kansas,

Appellant/Cross-Appellee.

ANTHEM INSURANCE COMPANIES, INC.,

Appellee/Cross-Appellant,

v.

KATHLEEN SEBELIUS, in her official Capacity
as Commissioner of Insurance for the State of Kansas,

Appellant/Cross-Appellee.

# BRIEF OF *AMICUS CURIAE* NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Appeal from the District Court of Shawnee County
Honorable Terry L. Bullock
District Court Case Nos. 02-C-340 and 02-C-341

Ross S. Myers
Kansas Supreme Court # 13623
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
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National Association of Insurance Commissioners

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Statutes, Regulations, Rules and Other Authorities:

## STATEMENT OF THE NATURE OF THE CASE

*Amicus curiae* National Association of Insurance Commissioners adopts the Statement of the Nature of the Case set out by Appellant/Cross-Appellee Kathleen Sebelius in her brief.

## STATEMENT OF THE ISSUES

Whether the District Court erred in ruling that the Commissioner of Insurance cannot consider the likely post-acquisition conduct and status of a holding company and the domestic insurance company it desires to acquire in order to determine whether "the plans or proposals which the acquiring party has" are "unfair and unreasonable to policyholders of the insurer and not in the public interest" or "hazardous or prejudicial to the insurance-buying public."

## STATEMENT OF FACTS

*Amicus curiae* National Association of Insurance Commissioners adopts the Statement of Facts set out by Appellant/Cross-Appellee Kathleen Sebelius in her brief.

## ARGUMENTS AND AUTHORITIES

### Standard of Review

*Amicus curiae* National Association of Insurance Commissioners adopts and incorporates into this brief the citations to the appropriate standard of review set out by Appellant/Cross-Appellee Kathleen Sebelius in her brief.

### Argument

The National Association of Insurance Commissioners (NAIC) is a non-profit corporation whose membership consists of the principal insurance regulatory officials of the fifty States, the District of Columbia, the territories and insular possessions of the United States. Started in 1871, it is the nation's oldest association of state government officials. The members of the NAIC completely control the same.

In filing this *amicus curiae* brief, the NAIC seeks to demonstrate its interest in this proceeding and to fulfill the mission of the NAIC, as set out in its Annual Report, to:

> ... assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:
>
> 1. Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
> 2. Promote the reliability, solvency, and financial solidity of insurance institutions; and
> 3. Support and improve state regulation of insurance.

This cause concerns the interpretation of and analysis of the scope of the Commissioner's discretion under K.S.A. 40-3304. This statute is based on the model NAIC Insurance Holding Company System Regulatory Act. Insurance Holding Company System Regulatory Act, NAIC, *Model Laws, Regulations and Guidelines*, p. 440 (1992).

The first version of the act was drafted by a committee of the NAIC and adopted by its members in 1969. 1969 *Proceedings of the NAIC* Vol. II, p. 738. Every state in the country has adopted this act (with the exception of New York and Wisconsin, which have enacted comparable laws). State Adoption Chart, Insurance Holding Company System Regulatory Act, NAIC, *Model Laws, Regulations and Guidelines*, p. 440-29 (2002) (attached as the Appendix). The members of the NAIC are thus vitally interested in this Court's interpretation of the same since the very same language that will be construed by this Court in order to decide this case is relied upon by the commissioners, directors and superintendents of insurance throughout the country in making decisions that greatly affect the public interest.

The members of the NAIC believe that the intent of the membership when it drafted the language of and adopted the model act and the intent of the Kansas legislature when it enacted the model act was to authorize the Commissioner to do exactly what the plain language of the model act and K.S.A. 40-3304 authorizes - approve or disapprove any acquisition or control of a domestic insurer after considering its "plans and proposals" for the future and after considering how "likely" the acquisition, if allowed to go forward, would be hazardous or prejudicial to Kansas citizens. Indeed, all of K.S.A. 40-3304(d) reflects the legislature's instruction that the Commissioner of Insurance must examine the likely post-acquisition effect of the subject transaction. Terms such as "might jeopardize," "plans or proposals," and "likely" clearly communicate the legislature's command to the Commissioner to pass on the proposed acquisition now, rather than attempt to repair or prevent injury to the public at a much later date, when it may be too late to fully protect "the public interest and the interests of policyholders."

K.S.A. 40-3301(b). To the extent that the District Court ruled otherwise, the members of the NAIC respectfully disagree.

The reasoning behind authorizing the Commissioner to rule on the transaction now rather than take subsequent remedial action goes to the heart of insurance regulation.

> ... there should be effective state supervision of insurers in their relationship with holding companies. Such supervision is a proper and natural extension of the responsibility of regulatory authority to assure, in the public interest, the solvency of the insurer and the protection and fair treatment of policyholders. Insurance is a business that is dependent completely on public confidence. Its contracts underwrite contingencies that may be long deferred or promise payments to be made many years in the future. Patronage of insurers is dependent upon the confidence of the buyer that the insurer can and will discharge its obligations in the manner provided in its contract. Because of the intangible nature of the insurance promise and its enormous significance to the social and economic structure as well as to the parties of the contract, the insurance business over many decades has developed and maintained a philosophy and ethics and practices on a level far above those that are generally accepted in the marketplace. Sound regulation of the insurance business by the states has reinforced this unique status of insurers and such regulation has been a principal bulwark of the public confidence that the business enjoys.

1969 *Proceedings of the NAIC* Vol. I, p. 178.

The members of the NAIC submit that the District Court has in effect taken away the legislature's charge to the Commissioner to regulate insurance holding company acquisitions. Furthermore, the District Court ignores the logical result of the method of regulation its order commands. If there is approval of the acquisition and then a future denial by the Commissioner of applications for rate increases and the very significant reduction in surplus, Anthem would be left with an acquisition that will not perform as it had planned. This scenario could well result in Anthem not devoting the resources to Blue Cross and Blue Shield of Kansas that it originally intended to devote and end in Anthem spinning off or selling Blue Cross and Blue Shield of Kansas, subjecting the

company, its policyholders, health care providers and the people of Kansas to the resulting turmoil. The Kansas legislature never intended that holding company transactions be regulated in such a harmful way. "We believe that state authority in the area of insurance regulation should enjoy a presumption of validity. We refuse to adopt the position of requiring the least intrusive means of protecting insurance company – policyholder relations ...." *Professional Investors Life Insurance Company, Inc. v. Roussel*, 528 F. Supp. 391, 402 (D. Kan. 1981).

Holding company acts in every area of business, banks, utilities, savings and loans, railroads, all provide for the governmental regulator to determine what will most likely happen in the future if an acquisition is allowed to proceed (*e.g., Public Service Company of New Mexico v. New Mexico Public Service Corporation*, 747 P.2d 917, 920 (N.M. 1987)) and to approve or disapprove the proposed acquisition based on the public interest. *E.g., New York Central Securities Corporation v. United States*, 287 U.S. 12, 24-25, 53 S. Ct. 45, 49 (1932). To argue that the Commissioner of Insurance, or any governmental regulator, has no discretion to take action to protect the public interest absent illegal acts or a statutory violation is to invite disaster. Clearly, there can be no rational argument that the public interest can only be harmed by illegal acts. If that is the case, then there is no need for administrative agencies, only prosecutors.

With regard to this issue, the Kansas legislature has spoken. It has stated that the Commissioner of Insurance can deny a proposed acquisition if it is not in the public interest. It has not stated that the public interest is adversely affected only when there is or will be an illegal act or statutory violation. Indeed, in this matter the Kansas legislature has set out examples of when the public interest may be adversely affected so that there

can be no doubt that it did not in any way intend that the Commissioner's discretion in this matter be limited to only consideration of possible illegal acts. K.S.A. 40-3301(b) states "... the public interest and the interests of policyholders are or may be adversely affected when: (1) control of an insurer is sought by persons who would utilize such control adversely to the interests of policyholders; ... (3) an insurer which is part of a holding company is caused to enter into transactions or relationships with affiliated companies on terms which are not fair or reasonable ...." This language simply does not allow for an interpretation which holds that only violations of statutory provisions would "adversely affect" the "public interest."

In passing on a petition for approval of acquisition of stock control of ten percent or more of a domestic insurer the New York Supreme Court, Appellate Division, held "the Department is more than an 'umpire blandly calling balls and strikes' in fulfilling its statutory responsibility ... [a]nd since the very depth and breadth of the record and the comprehensiveness of the opinion-decision dispel the claim of departure from the Superintendent's responsibility, we unanimously confirm." *American Reinsurance Company v. Schenck*, 47 A.D.2d 517, 518, 363 N.Y.S.2d 593, 595 (N.Y. App. Div. 1975). Regulatory agencies in many areas have been given wide discretion when charged with protecting the "public interest." "[I]n determining what constitutes the 'public interest' ... the Commission is entrusted with the function not merely of determining the existence or non-existence of certain facts, but also of exercising an expert judgment ...." *Pittsburgh and Lake Erie Railroad Company v. United States*, 294 F. Supp. 86, 97 (W.D. Pa. 1968). "In general, where the Commission is required to consider the 'public interest,' it must look to 'the interest of the public, their needs and necessities and

location and, in fact, all the surrounding facts and circumstances to the end that the people be adequately served.'" *Browning Freight Lines, Inc. v. Wood*, 570 P.2d 120, 126 (Idaho 1978). "[P]ublic interest may be taken to encompass a wide range of considerations, from environmental, health, and safety concerns to the financial concerns of employers, employees, and ratepayers." *General Motors Corporation v. Indianapolis Power & Light Company*, 654 N.E.2d 752, 762 (Ind. App. 1995).

It is also difficult to accept the argument by Appellees that the Commissioner relied on speculation, conjecture and supposition in making her ruling when the very same Appellees, under oath, filed a Form A with the Commissioner in accordance with K.A.R. 40-1-28 setting out in detail their future intentions with regard to post-acquisition conduct. Form A requires the following disclosure:

ITEM 5. FUTURE PLANS OF INSURER

> Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

Form A, Insurance Holding Company System Model Regulation With Reporting Forms and Instructions, NAIC, *Model Laws, Regulations and Guidelines*, p. 450 (1986).

The members of the NAIC do not believe that making a decision based in part on the detailed, declared future plans filed with the Commissioner pursuant to Kansas law (as well as the sworn testimony of Appellees' representatives) can properly be labeled speculation, conjecture and supposition, especially by the same parties who drafted and filed the plans and so testified, unless those parties are now asserting that those very plans and testimony were in fact speculation, conjecture and supposition.

## CONCLUSION

In construing the meaning and purpose of the Kansas Insurance Holding Company Act, the members of the National Association of Insurance Commissioners, the nation's oldest association of state government officials, firmly believe that it was and is the intent of the Kansas legislature to give the Commissioner of Insurance broad authority to consider the potential post-acquisition consequences of a proposed acquisition in order to fully protect policyholders and the general public and that this statutory purpose should guide this Honorable Court. The members of the National Association of Insurance Commissioners believe the protection of insurance consumers is the ultimate goal of any insurance regulatory system. Thus, statutes enacting an insurance regulatory system should be broadly interpreted with that legislative purpose in mind.

Wherefore, *amicus curiae* asks that this Honorable Court, in any rulings it may hand down in this cause, support and affirm the intent of the legislature to grant the Commissioner of Insurance the authority to weigh the likely future consequences of a proposed insurance holding company acquisition in approving or disapproving of the same.

Respectfully submitted,

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

## THE INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments. The model includes the Merger and Acquisition Law as Section 3.1. See KEY at end of list.

| NAIC MEMBER | MODEL/SIMILAR LEGIS. | RELATED LEGIS./REGS. |
|---|---|---|
| Alabama | ALA. CODE §§ 27-29-1 to 27-29-14 (1973/1994). | |
| Alaska | ALASKA STAT. §§ 21.22.010 to 21.22.200 (1976/1995) [1] | |
| Arizona | ARIZ. REV. STAT. ANN. §§ 20-481 to 20-481.30 (1978/2002) [1, 2] | |
| Arkansas | ARK. CODE ANN. §§ 23-63-501 to 23-63-530 (1971/1993) [1] | |
| California | CAL. INS. CODE §§ 1215 to 1215.16 (1969/2000) (Amendments pending in AB 1727 (carried over to 2002) would add [2]). | *See also* BULLETIN 93-6 (1993). |
| Colorado | COLO. REV. STAT. §§ 10-3-801 to 10-3-814 (1969/1992) (Contains part of § 3.1) | |
| Connecticut | CONN. GEN. STAT. §§ 38a-129 to 38a-140 (1969/1995). | |
| Delaware | DEL. CODE ANN. tit. 18 §§ 5001 to 5015 (1973/1995) [1] | |
| District of Columbia | D.C. CODE §§ 31-701 to 31-714 (1993/2002) [1, 2] | |
| Florida | FLA. STAT. §§ 628.801 to 628.803 (1985/1997) (§§ 8, 9, 10 of model); §§ 628.451 to 628.461 (1969/1999); FLA. ADMIN. CODE §§ 4-143.045 to 4-143.050 (1970/1991) (§§ 1, 4, 5 of model). | |
| Georgia | GA. CODE ANN. §§ 33-13-1 to 33-13-15 (1970/1993) [1] | |
| Guam | NO ACTION TO DATE | |
| Hawaii | HAWAII REV. STAT. §§ 431:11-101 to 431:11-117 (1988/2000) [1] | |

THE INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

| NAIC MEMBER | MODEL/SIMILAR LEGIS. | RELATED LEGIS./REGS. |
|---|---|---|
| Idaho | IDAHO CODE §§ 41-3801 to 41-3820 (1972/1999) [1] | |
| Illinois | 215 ILL. COMP. STATS. 5/131.1 to 5/131.28 (1977/1998) [1] | |
| Indiana | IND. CODE §§ 27-1-23-1 to 27-1-23-13 (1971/1999) [1] | |
| Iowa | IOWA CODE §§ 521A.1 to 521A.13 (1970/1997). | |
| Kansas | KAN. STAT. ANN. §§ 40-3301 to 40-3315 (1975/1997) [1] | |
| Kentucky | KY. REV. STAT. §§ 304.37-010 to 34.37-150 (1972/1998); § 304.24-410 (1996) [1] | |
| Louisiana | LA. REV. STAT. ANN. §§ 22:1001 to 22:1015 (1991/1997). | |
| Maine | ME. REV. STAT. ANN. tit. 24-A § 222 (1969/1999). | |
| Maryland | MD. ANN. CODE INS. §§ 7-101 to 7-807 (1969/2000) [1] | |
| Massachusetts | MASS. GEN. LAWS ch. 175 §§ 206 to 206D (1993). | |
| Michigan | MICH. COMP. LAWS §§ 500.1301 to 500.1379 (1970/1995). | |
| Minnesota | MINN. STAT. §§ 60D.09 to 60D.29 (1971/1999) [1] | |
| Mississippi | MISS. CODE ANN. §§ 83-6-1 to 83-6-43 (1974/2001). | |
| Missouri | MO. REV. STAT. §§ 382.010 to 382.302 (1983/1993) [1] | |
| Montana | MONT. CODE ANN. §§ 33-2-1101 to 33-2-1125 (1971/1999). | |

## THE INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

| NAIC MEMBER | MODEL/SIMILAR LEGIS. | RELATED LEGIS./REGS. |
|---|---|---|
| Nebraska | NEB. REV. STAT. §§ 44-2120 to 44-2153 (1991/2001). | |
| Nevada | NEV. REV. STAT. §§ 692C.010 to 692C.490 (1973/1995). | |
| New Hampshire | N.H. REV. STAT. ANN. §§ 401-B:1 to 401-B:17 (1971/2000)# | |
| New Jersey | N.J. REV. STAT. §§ 17:27A-1 to 17:27A-14 (1970/1996) [1] | *See also* N.J. REV. STAT. §§ 17:27B-1 to 17:27B-6 (1971). |
| New Mexico | N.M. STAT. ANN. §§ 59A-37-1 to 59A-37-28 (1985/1999). | |
| New York | | N.Y. INS. LAW §§ 1501 to 1510; 1601 to 1612; 1701 to 1716 (1984/1999); 7101 to 7119 (1984/1989) (Parts of model included). |
| North Carolina | N.C. GEN. STAT. §§ 58-19-1 to 58-19-70 (1971/2001). | |
| North Dakota | N.D. CENT. CODE §§ 26.1-10-01 to 26.1-10-12 (1983/2001) [1] | |
| Ohio | OHIO REV. CODE ANN. §§ 3901.32 to 3901.37 (1971-1972/2002). | |
| Oklahoma | OKLA. STAT. tit. 36 §§ 1651 to 1663 (1970/1999). | |
| Oregon | OR. REV. STAT. §§ 732.517 to 732.592 (1971/2001) [2] | |
| Pennsylvania | PA. UNCONS. STAT. §§ 40-10-101 to 40-10-113 (1993/2001) [1] | |
| Puerto Rico | NO ACTION TO DATE | |
| Rhode Island | R.I. GEN. LAWS §§ 27-35-1 to 27-35-14 (1971/2002). | |
| South Carolina | S.C. CODE ANN. §§ 38-21-10 to 38-21-390 (1988/2002) [1] | |

## THE INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

| NAIC MEMBER | MODEL/SIMILAR LEGIS. | RELATED LEGIS./REGS. |
|---|---|---|
| South Dakota | S.D. CODIFIED LAWS ANN. §§ 58-5A-1 to 58-5A-77 (1972/1993). | |
| Tennessee | TENN. CODE ANN. §§ 56-11-201 to 56-11-215 (1986/2000) [1] | |
| Texas | TEX. INS. CODE ANN. art. 21.49-1 (1971/2001). | |
| Utah | UTAH CODE ANN. §§ 31A-16-101 to 31A-16-111 (1986/1999). | |
| Vermont | VT. STAT. ANN. tit. 8 §§ 3681 to 3694 (1971/1996). | |
| Virgin Islands | NO ACTION TO DATE | |
| Virginia | VA. CODE §§ 38.2-1322 to 38.2-1346 (1986/2001) [2] | *See also* VA. CODE §§ 38.2-4230 to 38.2-4235 (1989) (Regarding nonstock corporations that are members of holding co. system). |
| Washington | WASH. REV. CODE ANN. §§ 48.31B.005 to 48.31B.902 (1993/2000) [1] | *See also* HB 1792 (2001) (Holding company act for health care service providers and HMOs). |
| West Virginia | W. VA. CODE §§ 33-27-1 to 33-27-14 (1974/2001). | |
| Wisconsin | | WIS. STAT. §§ 617.01 to 617.25 (1969/1998). |
| Wyoming | WYO. STAT. §§ 26-44-101 to 26-44-117 (1991/1994). | |

KEY

[1] Includes Section 3.1 on mergers and acquisitions.

[2] Includes confidentiality provisions adopted by NAIC in Jan. 2000 or similar provisions.

## CERTIFICATE OF SERVICE

I hereby certify that five true and correct copies of the foregoing were served by regular U.S. mail, first class postage prepaid, upon each of the following this 25th day of November, 2002:

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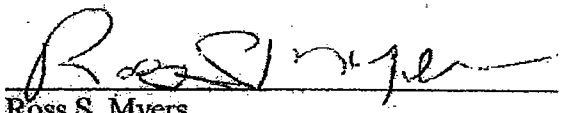

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